SAGE Specialty Pharmacy
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SAGE Specialty Pharmacy Vaccine Consent Form

Name (Please Print):	Gender	Date of Birth	Medicare ID / Last 4 SSN:

Street Address:	City	State	Zip	Phone Number:

Rx BIN:	RxPCN:	RxID:	RxGroup:

1. Which vaccine(s) are you requesting today?				
☐	COVID-19	☐	Hepatitis A and B	
☐	Influenza (Flu shot)	☐	Measles, Mumps and Rubella (MMR)	
☐	Respiratory Syncytial Virus (RSV)	☐	Meningitis	
☐	Shingles	☐	Chicken Pox (Varicella)	
☐	Pneumonia	☐	Typhoid	
☐	Tetanus, Diphtheria , Pertussis (Tdap or Td))	☐	Polio	
☐	Human Papillomavirus (HPV)	☐		

2. Are you sick today?	Y	N
3. Have you ever had a serious reaction after receiving a vaccination?	Y	N
4. Do you have severe allergies to any medications, food, vaccine or latex?	Y	N
5. Have you had a seizure or nervous system problem? (e.g. Guillain-Barré)	Y	N
6. Are you pregnant or is there a chance you could become pregnant during the next month?	Y	N
7. Have you ever felt dizzy or faint before, during, or after a shot?	Y	N
8. Are you anxious about getting a shot today?	Y	N
Answer questions 9-10 only for Shingles Vaccine:		
9. Do you currently have Shingles?	Y	N
10. Have you ever had Shingles, Chickenpox or received Chickenpox Vaccine?	Y	N
Answer questions 11-12 only for Pnuemonia / RSV Vaccine:		
11. Do you have alcoholism or do you smoke cigarettes?	Y	N
12. Do you take steroids, anticancer drugs or other immunosuppressants?	Y	N
Answer question 13 only for COVID:		
13. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?	Y	N
Answer questions 14-15 only for MMR Vaccine:		
14. Do you have long-term health problems? (e.g. Heart/liver/lung/kidney disease, diabetes, asplenia, CSF leak, cochlear implants or blood disorder)	Y	N
15. Do you have cancer, HIV, organ transplant, autoimmune/inflammatory disease or any other immune system problems?	Y	N

I have read, or had explained to me, the Vaccine Information Statement (VIS) and/or the FDA Emergency Use Authorization Fact Sheet for the COVID-19 vaccine. I understand the benefits and risks of this vaccine and ask that the vaccine be given to me or the person for whom I am authorized to make this request. I have been made aware of the appropriate time I am expected to be monitored for post-vaccination reactions based on my risk factors. I hereby attest to the best of my knowledge that I am currently eligible to receive the vaccine(s) requested. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination described. I request the vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for other public health purpose such as reporting to WIR (Wisconsin Immunization Registry).

Signature of Recipient (Parent or Guardian): **Date:**

Pharmacy Use Only

Vaccines given:	Manufacturer:	Lot & Exp	Route & Site: IM - Deltoid		WIR history checked	☐
			Right	Left	VIS given to Patient	☐
			Right	Left	Entered in WIR	☐
			Right	Left	Paid Claim	☐
			Right	Left	Counsel	☐
Signature:_____ Registered Pharmacist					Date of Administration:	